CSHCS REQUEST TO ADD AND/OR TERMINATE OTHER INSURANCE

Michigan Department of Community Health

INSTRUCTIONS:

- Please PRINT or TYPE.
- Retain a COPY in LHD Case File
- Attach clear copy of insurance card (**front and back**) when adding insurance

Mail to:

REVENUE AND REIMBURSEMENT DIVISION
BUREAU OF FINANCIAL MANAGEMENT
MICHIGAN DEPT. OF COMMUNITY HEALTH
PO BOX 30435
LANSING MI 48909

FAX
Adds or Terminations
(517) 346-9817

E-Mail
Adds with card copies attached
Terminations
TPL_Health@Michigan.Gov

SECTION 1 – Local Health Department Information

LHD Staff Person/Title	Date	County
Local Health Department	Medicaid Guar	
Local Health Department Phone Number ( )	Case Number (if available)	

SECTION 2 – List of Clients to Add Insurance

Client Name	Client ID Number	Date of Birth	Client Name	Client ID Number	Date of Birth
Client Name	Client ID Number	Date of Birth	Client Name	Client ID Number	Date of Birth

SECTION 3 – Add Health Insurance (including Medicare)

Policyholder Name	Social Security Number	Date of Birth
Commercial Insurance Name		
Member Number	Contract Number	Group/Policy Number

SECTION 4 – Add Additional Insurance

Pharmacy Insurance	Dental Insurance	Vision Insurance

SECTION 5 – Policyholder Employer Information

Employer Name
Employer Address (City and State)

SECTION 6 – List of Clients to Terminate Insurance

Client Name	Client ID Number	Date of Birth	Commercial Insurance Name
Client Name	Client ID Number	Date of Birth	Commercial Insurance Name
Client Name	Client ID Number	Date of Birth	Commercial Insurance Name
Client Name	Client ID Number	Date of Birth	Commercial Insurance Name

AUTHORITY: Title XIX of the Social Security Act